REQUEST A QUOTE

Key Employee Insurance

1. INSURED'S INFORMATION *This is NOT an application for insurance. It is a preliminary evaluation to assist with determining insurability only.*

Name: _____ Soc Sec # ____-____-____ Date of Birth: ____/____/____

Home Address:_____ City:_____ State: _____ Zip:_____

Home Phone #: (_____) _____ Work Phone #: (_____) _____ Gender: ☐ Male ☐ Female

Height: _____ ft. _____ in. Weight: _____ lbs Tobacco Use: ☐ Yes ☐ No If yes, type: _____ Date last used: _____

Occupation: _____ Employer: _____

Are You or Your Employer an ACCE Member? ☐ Yes ☐ No Annual Income: $_____ Net Worth: $_____

Are you a US Resident? ☐ Yes ☐ No Are you a US Citizen? ☐ Yes ☐ No If either is No, what country? _____

2. COVERAGE INFORMATION

Face Amount: $ _____ Policy Type: ☐ Indiv. ☐ Surv. ☐ UL ☐ GUL ☐ WL ☐ VUL

Proposed Premium: $ _____ ☐ Single Pay ☐ Term Years level: _____ ☐ ROP State of Issue:_____

Total Insurance In-Force Now: $ _____ Date Last Purchased: ____/____/____ Rated? ☐ Yes ☐ No

Will new insurance replace an in-force insurance? ☐ Yes ☐ No

Will this be a 1035 Exchange? ☐ Yes ☐ No If Yes, approximate exchange? $_____

Have you ever been declined or rated for insurance? ☐ Yes ☐ No If Yes, please provide details:_____

3. MEDICAL PROVIDER INFORMATION

Name of Primary Care Physician: _____ Date Last Consulted: ____/____/____ Reason: _____

Address:_____ City:_____ State: _____ Zip:_____ Phone: (_____) _____ - _____

Current diagnosis and medications: _____

Name of Specialist: _____ Date Last Consulted: ____/____/____ Reason: _____

Address:_____ City:_____ State: _____ Zip:_____ Phone: (_____) _____ - _____

4. GENERAL INFORMATION *Please check any items or activities from the list below that apply and provide details.*

A. ☐ Cardiovascular ☐ Heart ☐ Angina ☐ Stroke ☐ HBP

B. ☐ Cancer ☐ Location _____

C. ☐ Diabetes ☐ Type 1 ☐ Type 2 Age at dx: _____

D. ☐ Any other medical conditions including:
☐ mental/nervous ☐ respiratory ☐ urinary ☐ gastrointestinal

E: ☐ Drug Abuse ☐ Alcohol Abuse

F. ☐ Personal bankruptcy

G. ☐ Driving record ☐ DWI/DUI ☐ Violations

H. ☐ Private aviation

I. ☐ Hazardous avocations:_____

J. ☐ Travel or residence outside the US or Canada

K. ☐ Other:_____

Details A through K: _____

AGENT TO COMPLETE THIS SECTION

Agent/Advisor Name: _____ SSN:____ - ____ - ____ Email: _____

Firm: _____ Branch City: _____ Business Phone (____) ____ -_____

Licensed in: Residence state of insured: ☐ Yes ☐ No Owner State: ☐ Yes ☐ No Trust State: ☐ Yes ☐ No

5. AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

_____ _____/_____/_____

Name of Proposed Insured/Patient (First, Middle, Last) **Date of Birth**

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to CAPITAS FINANCIAL and its agents, employees and representatives. This includes any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition. Such records and information to be released may include, but are not limited to, the following: alcohol or drug abuse treatment, psychiatric treatment (but not psychotherapy notes), pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKGs.

By signing below, I amend my agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction to CAPITAS FINANCIAL.

My protected health information is to be disclosed under this Authorization so that CAPITAS FINANCIAL may disclose this information to the insurance companies below for the following purposes: 1) underwrite my application for coverage by making eligibility, risk rating, policy certificate issuance and enrollment determinations; 2) administer claims and determine or fulfill responsibility for coverage and provision of benefits; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with an insurance company. CAPITAS FINANCIAL does not make insurance approval decisions regarding this protected health information.

Insurance companies with whom we may share the information:

Allianz	Banner	Lincoln Benefit	New York Life	Transamerica
American General	Capitas Financial, LLC	Lincoln Financial	Pacific Life	Sun Life
American National	Genworth	MetLife	Principal	West Coast Life
Aviva	ING	Minnesota Life	Protective	Other: _____
AXA	John Hancock	Nationwide	Prudential	

This Authorization will remain in effect a maximum of twenty-four (24) months, or for the greatest timeframe allowed under applicable state laws, rules or regulations, following the date of my signature below and a copy of this Authorization is as valid as the original. I understand I have the right to revoke this Authorization in writing at any time, by sending a written request of revocation to: CAPITAS FINANCIAL, [Address], but that my revocation will not be effective until it is received by My Providers. I understand that this revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that an insurance company has the legal right to contest a claim under an insurance policy/certificate or the contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I understand that if I refuse to sign this Authorization, the insurance companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge I have received a copy of this Authorization.

Signature of Proposed Insured/Patient or Personal Representative **Date**

Description of Personal Representative's Authority or Relationship to Proposed Insured Patient

Return to: Willis of Maryland
12505 Park Potomac Avenue #300, Potomac, MD 20854
Fax to: (610) 254-5600
Questions? Call (610) 260-4369